



Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Inspection of *Children's* Services

in Neath Port Talbot

April 2015

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Introduction

Neath Port Talbot (NPT) Children's Services was made subject to Care and Social Services Inspectorate Wales' (CSSIW) serious concerns protocol in November 2012. Quarterly monitoring arrangements have been in place to assess progress made by the local authority in delivering its strategic improvement plan. A further inspection in November 2013 resulted in the protocol remaining in place.

This report relates to the inspection undertaken in February 2015. Inspectors focussed on whether sufficient progress had been made to improve the quality and consistency of services for children and young people in need of support or protection, including those who were looked after and care leavers. Inspectors read case files and interviewed staff, managers and professionals from partner agencies. Wherever possible, they talked to children, young people and their families. In addition inspectors evaluated the potential for the local authority to sustain and further develop improvements in the service.

The inspection team would like to thank Neath Port Talbot elected members, staff, partner agencies and service users who contributed to this inspection.

Conclusions

The inspection primarily focussed on the progress made by the local authority in implementing the 22 recommendations made in the last inspection report (see appendices). The recommendations fall into four themes which are outlined below.

Theme 1: Providing direction

Strong political and corporate support for the improvement plan was evidenced by the clear priority which had been given to its implementation. There had been sustained targeted investment in the workforce and resources which had resulted in a much improved and consistent delivery of children's services. Elected members and the corporate management team demonstrated a common understanding of the direction and drive needed to ensure the service effectively supported improved outcomes for children and young people in Neath Port Talbot (NPT). Elected members were knowledgeable about performance and were able to identify areas which still required improvement. Scrutiny arrangements had been further developed and strengthened. The corporate parenting panel had raised its profile across the authority and some progress in improving outcomes for looked after children had been made. Partner agencies were well engaged strategically and evidenced good understanding of the complex issues facing the authority. Whilst there were some inconsistencies between the effectiveness of strategic and operational arrangements in both areas, there was evidence of improvements being made in working together. Strong support was expressed for the commitment needed to ensure there would be a continuous improvement agenda, with an acceptance that the authority face a challenging economic environment with a legacy of the highest looked after population in Wales and continued demanding levels of need.

Leadership of children's services showed significant improvement from the time of the last inspection. The senior management team enjoyed a high level of respect and credibility from the workforce, who in turn believed they were listened to and valued for the enormous amount of effort being made to improve timeliness and quality of services. Workers had a greater common understanding of the approach being used to manage high demand for services; support children to live in the community; and reduce the number of children looked after.

Theme 2: Delivering social services

Sustained stability in the workforce, including reduction in the use of agency workers to cover staff sickness absence rather than vacancies, had made a significant contribution to improvements in continuity and consistency of practice. Better induction, relevant training and staff guidance had supported positive workforce development. There was some vulnerability noted in certain teams and a need to further support the development of the team manager group. These issues had been identified by senior managers and additional supportive arrangements were in place. While workers were

much clearer about the roles and responsibilities within teams, there was inconsistency in these arrangements across the service, which could impact effectiveness of consistent supervision and decision making.

Morale was high and there was no evidence of the bullying and oppressive culture reported at every previous inspection. There was a high degree of optimism that the improvements in the delivery of an effective and timely service would continue to progress. Workers were confident that the level of corporate and management support for the service would continue should the serious concerns protocol be lifted. Sustaining stability in the workforce, together with building on the experience throughout the operational management structure, will continue to require considerable effort and resource.

The implementation of the quality assurance framework appeared to be inconsistent. File audits were not systematically completed and learning from complaints or service user feedback to improve service provision was not clearly evidenced. A 'Performance Improvement Group' with membership from across the service was in operation and the outcomes from this work had led to some improvements in the quality and consistency of service delivery. There was an engagement and participation plan in place to roll out the strategy which was developed in 2013 but was yet to be implemented. Two posts had been agreed to help address this area for development.

Theme 3: Shaping services

Making good use of the local needs analysis had resulted in positive progress being made in the planning and shaping services, which had the potential to manage the high demand on statutory services and reduce the 'looked after population'. The joint review of all support services including those commissioned appeared to have been amended in an effort to quicken the pace of change. This had resulted in some fragmentation of the overall progress of the whole model. However, newly commissioned services appeared tailored to meet the identified needs with sound monitoring arrangements. It was too early at the time of the inspection to evidence how successful this service provision would be in reducing the need for children and young people to become looked after.

The demand for family support remained high and the volume of contacts with children services particularly with respect to domestic violence was marked. Managers and social workers were optimistic about the Team around the Family (TAF) service which had taken on 'child in need' cases helping to make team caseloads more manageable. There were plans in place to improve access to this service by way of a common gateway within children's services. TAF had become fully operational only three months previously and additionally the full range of 'edge of care' services were still in development. It will therefore be some time before this model can evidence success in better supporting families in the community and reducing the demand for statutory intervention. The degree to which workers and partner agencies were engaged in the development of the revised family support strategy was variable. However the majority had been kept informed about

the progress. There was still some confusion for workers around the exact remit of the 'edge of care' services and how the loss of general support services such as parenting for those in need and counselling for looked after children would have an impact on outcomes. Further analysis of how the needs of families, particularly those with older children and young people, could be better supported at an early stage would benefit the effectiveness of the family support strategy.

Theme 4: Assessment care management

The arrangements for managing contacts and referrals were mostly timely and effective. Thresholds between 'early help' and statutory social services interventions were generally appropriate and operating effectively. Consistency in the quality of initial assessments had improved and arrangements for signposting to TAF or other support services were better organised. The needs of the child were kept at the forefront of assessments but the recording of children's and families views remained inconsistent. It was noted that a number of older children and young people who were referred did not receive a timely assessment or appropriate early intervention.

Children and young people who were or were likely to be at risk of harm were identified and work completed appropriately to help keep them safe. The arrangements for child protection enquiries and investigations were timely and showed improvement in consistency and quality. Managers were aware that a need for more continuity and better information in preparation for strategy discussions had been identified by partners. The quality of risk assessment although improved from the previous inspection was still variable. Workers had completed appropriate training but further support and guidance particularly for risk management arrangements was needed.

Core group working was more effectively completed but the quality of child protection planning was variable. Workers appeared to lack confidence to fully develop the initial child protection plan which was agreed at the case conference. Partner agencies were sometimes hesitant to agree to children's names being removed from the child protection register (CPR), despite progress having been made to minimise risk. Case conference chairs did not always manage this challenge effectively. Although there has been a strong focus on multiagency training for child protection work, joint understanding of thresholds through the service remains an area for development. There had been a focus on reviewing the profile of children on the CPR reducing drift and escalating concerns where appropriate. Families did not always appear to be well engaged in the child protection planning and were not always clear about its purpose.

Transfer arrangements from the intake team to the community children's teams had improved significantly. Workers were clear about the process with the majority expressing satisfaction with the transparency and fairness of case allocation. Workloads were reported to be far more manageable and proactively reviewed. It was evident that some teams had more capacity to reflect on practice, carry out more dynamic assessment and increase direct work. Supervision was regularly completed but the quality of support and management oversight was variable; reported to be related to lack of capacity rather

than the ability of managers. Overall management oversight had improved since the last inspection.

The threshold for instigating the Public Law Outline (PLO) was appropriate and arrangements to seek legal advice were effective. The numbers of cases with this status had decreased significantly in the previous 12 months but several cases reviewed appeared to have drifted in the 'pre-proceedings' stage. The lack of consistent effective planning with little identification of outcomes against which progress could be measured could hamper timely decision making. The format of plans had improved which had facilitated better recording. However, care planning remained an area for development.

Social workers had a better understanding of the purpose of statutory visits and some very good direct work was evidenced on files seen by inspectors. The majority of looked after children's cases were appropriately allocated and permanency was more effectively reviewed. Considerable work had been completed to better equip the independent reviewing team to play a more active part in challenging the effectiveness of plans and to better quality assure arrangements. Children and young people were not being regularly seen by Independent Reviewing Officers before their reviews and consultation documents had been identified as needing significant improvement if they were to be used consistently.

Recommendations

Providing direction

1. Strong political and corporate support for children's services must continue if the improvements made are to be sustained and further consolidated.
2. The Corporate Parenting Panel should continue to focus on ensuring better outcomes for looked after children and young people are achieved and support improved mechanisms to gain the views of service users.

Delivering social services

3. The workforce strategy must include medium to long term aims for recruitment and retention of social workers. Arrangements for deputy team managers and consultant social workers should be reviewed to ensure the capacity to carry out their responsibilities is consistent across the service.
4. Caseloads must be continuously monitored to ensure there is sufficient capacity for workers to undertake direct work with children, young people and their families.
5. Leadership and development programmes should be made available to build resilience within the operational management team, and continued support is required for the development of the independent reviewing team.
6. The implementation of the Participation and Engagement action plan should be given priority.
7. The quality assurance framework must be systematically implemented across the service. The quality of supervision should be reviewed to ensure there is a consistent approach which represents an effective front line quality assurance process.
8. The complaints service should be monitored consistently to ensure there is sufficient resource and capacity available to manage it effectively. Better organisational learning should be derived from complaints to improve the quality of services.

Shaping services

9. The looked after children's strategy should be reviewed to ensure that services focus on emotional well being and that the best outcomes are achieved for those children and young people in long term care.
10. More interagency work is required to agree thresholds across the service particularly for decision making on stepping up and stepping down arrangements.

11. The Family Support Strategy should be reviewed to ensure there is clarity about eligibility and better integration between the support services across the tiered approach to meeting need. Arrangements to support families to engage in early preventative service also should be included.

Assessment care management

12. The effectiveness of arrangements to ensure the needs of children and young people are assessed, if concerns about their wellbeing are repeated, should be strengthened.
13. The multi-agency peer review group should consider trends in demand and monitor the thresholds for and the take up and effectiveness of preventative services.
14. Risk assessment training should be provided for unqualified support workers, and work to promote consistency in risk management should retain a strong focus.
15. Further improvement in the quality of care planning is required and in particular a greater emphasis on permanency arrangements for those in long term care.

Theme 1: Providing direction

What we expect to see

Leadership management and governance arrangements comply with statutory guidance and together establish an effective strategy for the delivery of good quality services and outcomes for children, young people and their families. The authority works with partners to deliver help, care and protection for children and young people and fulfils its corporate parenting responsibilities for looked after children. Leaders, managers and elected members have a comprehensive knowledge and understanding of practice and performance to enable them to discharge their responsibilities effectively.

Key findings

1. Leadership, management and governance arrangements complied with statutory guidance.
2. Elected members had a better understanding of how to interrogate performance and recognise the quality of services.
3. Communication and relationships with partners were working more effectively.
4. The voices of children and young people were not sufficiently captured or used to provide assurance that services were effective.
5. There was a common belief that the strategic direction for early intervention services was clear and credible.
6. Improving services and safeguarding children and young people was given priority on corporate agendas.
7. Corporate parenting arrangements were being embedded and starting to make a real difference but concerted effort will be required to ensure ongoing success.
8. The leadership shown by senior managers together with their visibility and accountability were valued throughout the workforce and by partner agencies.

Findings

Explanation of findings

1.1 Historically there had been strong commitment from elected members and corporate team to fully support the agenda for effective delivery of children's services. However this was challenged when the deterioration in performance over a number of years resulted in the serious concerns protocol being invoked. The leader of the council had encouraged elected members to engage directly with the workforce and report back on barriers to improvement. The children and young people and education scrutiny committee has benefited from support with developing their understanding and knowledge of both the strategic and operational elements of children's services. This has resulted in corporate arrangements being strengthened which had enhanced the ability to challenge performance and to begin to hold partner agencies to account.

1.2 The authority had put arrangements in place to drive improvement and ensure that safeguarding was a priority across the council. There were strong links between the strategic improvement implementation board, the local safeguarding group and the regional safeguarding children's board. Senior corporate officers and the director of social services had promoted the ethos of each individual taking responsibility for improvement. Partner agencies were committed to 'ensuring that safeguarding comes down to individual children not just high level discussion'.

Quote from a partner agency:

'There has been lots of buy-in from strategic people in the council and we have been involved in trying to put things right from the start.'

1.3 Elected members were able to give examples of what difference 'corporate parenting' has made to the outcomes for children and young people who were receiving services. These included supporting opportunities for looked after children to achieve academically and increasing the supported housing options for care leavers. There was a commitment to ensure young people were no longer placed in unsuitable bed and breakfast accommodation. This showed a critical change from previous inspections when corporate parenting was seen as passive rather than proactive. Given the significant increase in numbers of care leavers projected for the next two years, concerted effort will be required to ensure ongoing success of this initiative. Elected members still need to experience more direct contact with children and young people to hear for themselves whether the support they receive equips them to live independently in the future.

1.4 The director of social services and the head of service showed strong and ambitious leadership to drive improvement both strategically and operationally. Partners and staff were very positive about the influence that had been exerted to 'get things done' and remove any barriers to change. All the senior management team were described as approachable and transparent in their dealings with staff. This was reported to be a significant change in culture, and gave confidence to the workforce that their contribution was valued. Developments such as the 'performance improvement group' which is chaired by the head of service and leads directly to action being taken to improve practice issues illustrated for staff a more inclusive and collaborate approach.

Quote from corporate team member:

'The culture has changed within the authority – it is much more collaborative. We are not frightened to look critically at what we are doing.'

Theme 2: Delivering social services

What we expect to see

Services are delivered by a suitably qualified, experienced and competent workforce that is able to meet the needs of children, young people and their families. The council is able to ensure that staff and services meet the standards that have been set for them.

Key findings

1. Implementation of the workforce strategy had resulted in sustained and improved workforce stability since the last inspection.
2. Workers were positive about induction, training and development opportunities.
3. Supervision was mostly timely but quality of guidance and management oversight was variable.
4. Improved transfer arrangements had supported better continuity and workflow. Business support was more organised and supported staff to work more effectively.
5. Staff morale was high with no reports of recent bullying or oppressive practice.
6. Caseloads had reduced for most workers but some teams had higher workloads overall, which impacted on the quality and consistency of work undertaken with children and young people.
7. Roles and responsibilities within teams were better understood but varied throughout the service.
8. The senior management team members were valued for the timely and effective support they consistently provided for staff.
9. Performance management was well embedded and understood across the service.
10. The quality assurance framework was inconsistently implemented with limited service user feedback or organisational learning from complaints.
11. A number of panels were in operation to promote greater consistency of practice and assist in managing demand.

Quote from manager:

'The blue light culture has changed and we know what we are trying to achieve.'

Explanation of findings

2.1 The stability in the workforce which had been sustained and built on since the last inspection had contributed to a much more cohesive service. There was more continuity for families, children and young people and workers were able to access more consistent guidance and support for their work. Support from the dedicated HR staff had been crucial in achieving this. The profile of the workforce has also changed with a higher percentage having being qualified over two years. There was still some vulnerability at team manager level with six being in their current post for under a year and four of those new to the management role. The number of agency workers still being employed by the authority was down from 24 at the time of the last inspection to 11. Those who were in post were covering staff absence rather than vacant posts. There was also proactive management of agency workers with an induction and training programme in place, in addition to securing temporary contracts for some agency workers which gave greater continuity for service users. The workforce strategy should be reviewed to include medium to long term plans to recruit and retain qualified social workers. Staff found administrative support was better organised and supported their work more effectively.

2.2 The inconsistency both in staff competencies and quality in practice found during the last inspection was reduced considerably across the service. Staff had a greater understanding of the overall aims and direction of the work. Some workers were able to contrast the current situation with that of the difficulties evident in the previous two years. All but one team were very positive about morale, and reducing workloads. There was a high level of confidence that the senior management team would deal effectively with any concerns about bullying. One team had experienced a period of disruption both in their location and management of the team. Senior managers were aware of the concerns and plans were in place to address these matters. All workers interviewed were optimistic about the future of the service believing that the improvement agenda would continue to be supported, and that they were making a difference for the children and families with whom they were working.

2.3 There had been a comprehensive programme of appropriate training provided for staff, some of which was mandatory. There had been good attendance overall including for multi-agency training. Every worker was said to have an individual learning plan in place and the induction programme was reported to be positively received by staff and managers. Sound arrangements were in place to support the first year in practice and for staff to undertake the consolidation programme for newly qualified social workers. Staff appraisal was not consistent but workers were being offered opportunities for personal development across the service. The staff structure varied from team to team in accordance to the volume of work, local need or vacancies which had occurred as a matter of course. Workers were clear about the different roles of consultant social workers and deputy team managers although there was a variance in the responsibilities of the latter. While the development of different team roles appeared to be welcomed by staff, the structure needs to be reviewed to ensure that there is consistent supervision and quality assurance across the service.

2.4 There was considerable variation in workload across the community children's teams, which could be a consequence of differences in demand and local deprivation. However it was likely that this was also a legacy from the previous instability of the workforce which had a particular impact on some teams. The numbers of children on the child protection register (CPR) vary from 35 in one team to 70 in another with looked after children numbers varying from 21 to 57. Although the number of social workers in each team also ranged from 7 to 11, some deputy team managers were carrying up to 15 cases and others none. Although this role was making a sound contribution to the overall improvement in service provision, the difference in workloads had resulted in some teams having more capacity to develop reflective practice and progress cases more effectively. Concerns were noted in the last inspection about the high number of looked after children cases which were held by the community children's teams rather than the looked after children team. The numbers of cases in that team had only increased by 6 in the interim period but overall looked after children's cases in the community children's teams had reduced by 40. It was reported that out of 145 such cases, 71 were subject to placement orders or still within care proceedings and 25 children had been identified as appropriate to transfer to the looked after children team. The authority had identified the need to increase capacity in that team and 2 additional posts had been agreed. The permanency arrangements for these children and young people should be systematically reviewed to ensure that they receive the support needed to achieve the best outcomes.

2.5 There was ongoing monitoring of workloads and various arrangements put in place to support teams that were struggling with capacity. Workers had some anxiety that the support was time limited and were uncertain about future progress if it was discontinued. Senior managers were confident they had plans in place to improve the management of these concerns and staff would not be left unsupported.

Quotes from social workers:

'Morale in our team is very high, there is a supportive culture and supportive management.'

'Supervision often feels rushed and is not satisfactory.'

'I wanted to get experience of working a case in the public law outline. I was able to shadow a more experienced colleague, I had excellent support from my manager [and] my confidence has grown no end.'

'Still picking up the backlog from the past but getting better now.'

2.6 Transfer arrangements particularly between the intake and community children's teams had been significantly strengthened. Workers were clear about the process and knew what was expected before cases were transferred. All but one team reported that cases were discussed with them before allocation and they believed the process was transparent and fair. Supervision was timely and effective in most teams but there was variability in quality with a task centred focus and not enough direct guidance was

reported by some staff. A lack of reflection on practice and constructive challenge was noted in paperwork and files which were reviewed. Workers welcomed the openness from the senior management team about exploring different ways to deliver services more effectively. A number of developments in addition to reducing the looked after population were presented to inspectors including:

- assessing vulnerability and resilience in looked after children;
- dynamic parenting assessment;
- a unified assessment approach for special guardianship orders.

These initiatives were not yet being used across the service but the support for creative practice was evident and showed good potential to improve outcomes.

2.7 Performance management was well embedded across the service. Managers had good access to performance data, and the IT system supported potential further progress in data collection. Monthly management meetings were held to look at performance, analyse trends and decide what actions were to be taken when any 'hot spots' were identified. Workers had a more positive view of the need for performance management partially because the use of the dashboard system had been amended, and also because they had seen a significant improvement in timeliness over the past two years.

2.8 There had been piecemeal progress in implementation of the quality assurance framework. Some of this was due to an appropriate reduction in pace when it was identified that case file auditing was a development need across the service. However the auditing which has been completed appeared to focus on compliance rather than quality. Much effort had gone into working with the independent reviewing officers (IRO) so that they would be able to provide an effective quality assurance process that would assist service improvement. This was not well enough embedded at the time of the inspection to evidence the success of this approach. The development of this team continued to be a priority for the service. Some progress had been made through the work of the practice improvement group, but this did not address the need to have a systematic programme in place which would give continuous feedback on the quality of services. There was little evidence of how participation and consultation with services users had been used to inform service improvement. A number of specific events had been held which while positive in themselves were limited in their focus. There is an action plan in place to take forward the Engagement and Participation strategy and additional posts had been agreed to lead on these areas of work which need to be prioritised.

2.9 The considerable effort made by the director of social services and the head of children's services had contributed to a significant reduction in the number of complaints received in 2014. There was an emphasis on frontline manager's to respond to complaints in line with the new Welsh Government policy. However, overall the review of complaints documentation and discussion with staff did not give a level of confidence that there is a timely and effective system in place. The quality of complaint resolution was not coordinated and managed well. The independence of the service was not transparent and although the outcomes from complaints were considered by the team manager's

performance group, it was not evident how the learning was used consistently to improve the quality of services. The service was at a point of transition at the time of the inspection with the recent appointment to a revised complaints officer role. More attention needs to be given to supporting frontline staff in complaints resolution, to independent examination by managers and coordination by the complaints officer. The senior officer oversight and organisational learning need to be strengthened.

Practice example review of complaints:

The complaints monitoring forms were well conceived and contained all the right questions but none of the forms were completed fully and it was not possible to see whether cases had met the timescales. Due emphasis is given to the responsibility for frontline staff to seek resolution wherever possible but it is not clear whether, apart from some training, they receive ongoing support with this. From the records reviewed the role of the member of staff the complaint is against was not evident in securing a resolution.

Theme 3: Shaping services

What we expect to see

The services and support for children, young people and their families improves their outcomes. Work with partners in shaping the pattern and delivery of services is informed by local needs analysis assessment and includes the views and experiences of children and young people. Strategic plans are converted into commissioning arrangements which provide safe, quality services and deliver best value.

Key findings

1. Local needs analysis had been used well to shape and commission services.
2. Partner agencies were well engaged in the strategic planning but not all approved of the process, or agreed with all the outcomes.
3. The decision not to jointly review the early preventative and commissioned services had led to some fragmentation of the overall provision.
4. The voice of the child was not evident in shaping service planning.
5. Workers had been kept informed of the developments, and were optimistic about the outcomes that the 'Team around the Family' service might achieve.
6. Commissioning agreements were well developed with clear standards and expectations outlined to meet identified needs. Monitoring arrangements were focussed on outcomes and best value.
7. The looked after children's strategy focussed on the priority to reduce the numbers in care, but did not outline how the best outcomes for children and young people could be supported.
8. The strong strategic support for the direction of service delivery from partner agencies was not consistently translated into practice.

Findings

Explanation of findings

3.1 There was an early intervention and prevention commissioning strategy (2014-17) in place. The 'Think Family Partnership' had engaged partner agencies in planning the strategic direction of early preventative services. The amendment of the plan to jointly review the effectiveness of all services had not been understood by some partners. There was a perception that this could lead to a fragmented provision which was not fully integrated to meet the full range of need. However, overall they were positive about the potential for the proposed model of service delivery. Those targeted services which had been re-commissioned were shaped by local need with sound arrangements for monitoring and review. There was uncertainty at the time of the inspection about the continuity of the advocacy service and arrangements to provide this statutory provision after April 2015 had not been agreed. Some existing providers had not been able to engage with the authority to review the services they were delivering. This was reported to be as a result of the loss of a commissioning post. There were plans in place to start the re-commissioning of all the remaining targeted procured services in summer 2015 in order to commission the right support to meet need.

3.2 Two key strategies had been developed to help transform services and drive the agenda for change. The looked after children (LAC) strategy focussed on reducing the number of children already being looked after. A profile of the looked after population was used to support the strategy but this did not include a profile of need. Whilst a reduction in numbers is likely to free up resources and workers' time to provide more direct work, this has to be balanced with addressing the emotional vulnerability of children and young people, many of whom have experienced significant harm and abuse. The LAC strategy should be reviewed to ensure there is more focus on supporting children to enjoy positive well being and achieve their potential. The profile of the looked after children's population shows a high number of young people will become eligible for a pathway plan in the next two years (94). The leaving care team already holds a high number of cases and addressing a backlog in pathway planning was underway. The lack of accommodation for care leavers had already been identified and plans to ensure there is the capacity to support the projected increase in numbers of young people should be made. The draft family support strategy outlines the four tiered approach that NPT have chosen to meet identified need and carry forward the drive for more children and young people to be cared for in the community. Arrangements are included to ensure a 'step up – step down' approach but there is a lack of detail with respect to a fully integrated range of services. Staff and partners interviewed raised concerns that there was:

- a lack of therapeutic services for looked after children;
- an age limited restriction for some services;
- gaps in parenting and counselling support.

3.3 Senior managers would consider social workers making a 'business case' for any service to meet any identified need which was not being met. This approach was likely to present barriers for busy staff and the timely availability of such spot purchase arrangements would be difficult to guarantee. The identification of unmet need should be recorded and reviewed as part of the proposed re commissioning process.

Remaining areas for development (staff survey)

Better transition between children's services and adult services. More support for families (children between the ages of 3 and 7) as there is now a gap in service provision.

3.4 There was a common understanding amongst partner agencies of the strategic approach being used by the authority to reduce the looked after children population and staff. This consisted of two key elements, working to secure alternative permanency arrangements for those already in care and 'assuring quality family support and managing risk' to prevent children becoming looked after. The latter initiative will not reach full potential until the commissioned 'edge of care' and prevention services are fully operational later in 2015. However in the interim social work intervention is far more focussed on managing risk effectively while still ensuring children are being safely cared for. Examples were seen that illustrated partner agencies were not fully confident of this approach and more engagement is required with partner agencies to develop a shared understanding of thresholds both 'in stepping up' and 'stepping down' statutory interventions.

3.5 There had been a lack of capacity to progress work to engage systematically with children, young people and their families in service planning. An action plan has been developed and additional resource agreed to increase the pace in this area of work.

Quote from member of staff:

'Children's service is seen as having a high profile, but other partners view that it is still in the past – there a lack of confidence that services will be available unless managed through statutory process.'

Theme 4: Assessment care management

What we expect to see

Children and young people identified as being in need of help or protection, including children looked after, experience timely and effective multi-agency help and protection through risk-based planning authoritative practice and review that secures positive outcomes.

Key findings

1. Children and young people in need of protection received a timely and effective service, to help keep them safe.
2. Appropriate thresholds for access to statutory services were understood by partner agencies and children's services.
3. The needs of young people aged 11+ were not always effectively assessed which prevented them receiving timely preventative support.
4. The quality of initial assessments had improved and core assessments were more outcomes focussed.
5. Arrangements for better continuity, and organisation of workflow were in place.
6. Care planning although improved was inconsistent, and not always outcome focussed.
7. The quality of risk analysis within assessments and care planning was variable.
8. Case work was child focussed but did not articulate children's wishes and feelings often enough.
9. Core group working was more effective but workers lacked confidence to fully develop child protection plans, and parents had not been supported to understand the process.
10. Workers carried out more good quality direct work with children and young people.
11. Thresholds for the instigation of PLO were appropriate but some drift was noted in the pre-proceedings stage.

Explanation of findings

4.1 The arrangements for access to children's services had been reorganised since the last inspection which had resulted in improved effectiveness. The percentage of referrals on which a decision was made within one working day stood at 98.5% in the third quarter of 2014/15, a performance which had shown consistent improvement. Initially following re structuring in 2013 the intake team only screened contacts and referrals; this was expanded to include the responsibility for completing initial assessments (IA) with any cases needing child protection or on-going support transferred to the community children's teams. These arrangements were reviewed in 2014 and it was agreed that from November 2014, Section 47 enquiries would be completed by the intake team to improve timeliness and continuity. Case transfers were managed by weekly meetings which also provided an opportunity to further screen cases being stepped down to the TAF service. Social workers in the community children's teams reported they were able to plan and organise their work more effectively, and although a duty rota was still needed for any child protection enquires which came in on open cases this did not have a significant impact on their capacity to complete planned work. Workers in the intake team also expressed satisfaction with the revised arrangements which gave them a longer period of time to work with families and start to make a difference to their situations.

Parent comments:

'She (the social worker) is lovely, she speaks to me and listens, she understands and eases my mind.'

'Every time I ring if the social worker is not there she gets back to me later or the next day.'

4.2 Whilst the number of referrals showed a slight downward trend from 2013/14, the volume of work remained high, particularly with contacts from the police reporting incidents of domestic violence. The percentage of re-referrals had also reduced substantially in the previous year from 26% to 16%. Some of this reduction was the outcome of screening all contacts so that in those defined as referrals almost 100% went onto initial assessment. It was evident from data received from the authority that there was a high level of multiple contacts for some families. There was a protocol in place which stated that if more than 2 contacts were received on the same child or a sibling within a prescribed period an initial assessment would be undertaken. Inspectors noted that in some case files reviewed the protocol was not being followed. This had resulted in a lack of timely support being provided for some children. Managers were monitoring work in this area and thresholds were being scrutinised by means of a multi-agency peer review group which looked at cases which had raised concerns. It would be beneficial if there was a more holistic approach to these arrangements to consider trends and outcomes. This would also be an opportunity to check out the thresholds for referral to the TAF service. The potential to reduce the amount of statutory work being undertaken partially relies on effectiveness of this service which had not been in full operation long

enough at the time of the inspection for an evaluation to be completed. However data showed that of the 209 referrals made to TAF between April and December 2014, fewer than 50% of the families went on to take up a service. Additionally only 28 referrals were made by health visitors, who are best placed to identify need at an early stage. This had been identified as an issue and there were plans in place for a TAF worker to join the intake team, which already hosts a health and a substance misuse worker. There is a need to support families to engage with preventative services and for step up and step down arrangements to include this vital step.

4.3 The number of initial assessments completed in the period April to December 2014 had reduced from the same period for the previous year. Timeliness was consistently good with between 92% and 95% of assessments completed within seven days. The quality of initial assessments had improved and in most cases reviewed by inspectors, a good range of information had been used to develop the analysis of need. All assessments were signed off by managers in a timely way and included their comments. There was an inconsistency in which elements of the work were being quality assured by managers, which needs to be addressed. Revised templates for assessments included a prompt for recording the identification of risk. This did ensure that social workers included some consideration of risk but there was greater inconsistency in this area of assessment work. All social workers had completed risk assessment training, but further development particularly in recording the scale of the identified risk was needed. It would also be beneficial for practice support workers to undergo this training as they carry caseloads. Although not working with child protection cases it would be helpful for them to be able to identify risk at an early stage with 'in need' cases they were working.

Quote from staff survey:

'The procedures are in place to enable workers to safeguard and work with children and families to achieve positive outcomes, the performance improvement group (PIG) meeting is a great way to get management to listen to concerns in the teams and disseminate information.'

4.4 The quality of Section 47 investigations showed more consistency, and in cases reviewed appropriate action was taken to keep children safe. Recording of decision making and management oversight had also improved. The decision to move straight into the child protection investigation however was not always clearly recorded on the initial assessment. In these instances a core assessment was carried out as outlined in Welsh Government guidance. However in these cases there was no mechanism to capture and report whether a child had been seen alone. This was said to have contributed to a decline in performance to 38.7% in 2013/14. This deficit in the recording system should be addressed so there can be good management oversight of whether children are appropriately being seen alone.

4.5 The number of core assessments completed had reduced slightly in the first three quarters of 2014/15 to 636 from the same period the previous year. Timeliness for the completion of core assessments was consistently positive at 82%. The quality

of assessment work here varied more than in initial assessments. However progress had been made and there was evidence of good working relationships between social workers and families in those cases reviewed. The majority of outcomes were good or satisfactory. The extent to which children and young people were involved in their assessments was not routinely evident. The assessments completed for court proceedings were found to be much improved, comprehensive and clearly written.

Views expressed by parents:

'We thought the core assessment would be helpful but in the end it got a bit lost with so much going on. It was hard to work out what was meant to be happening.'

4.6 The number of open 'child in need' cases had reduced significantly since the last inspection from 1,152 to 733 at the end of January 2015. This had been achieved through systematic review of child in need plans which then led to closure of the case or stepping down to TAF service. There was a protocol in place for the transfer of such cases to reduce the time a family might have to wait for the new service to start. There was a waiting list for the TAF service at the time of the inspection, so these arrangements should be monitored to ensure there is no negative impact on progress made by families who had accessed social work support. There was evidence of effective direct work being carried out which was supported families to look after their children.

4.7 There was some inconsistency in the numbers of in need cases held by each team across the service, which had the potential to impact of the amount and intensity of work which could be carried out. The team which supported children with disabilities still had a high workload of 311 cases. However the team had no vacant posts nor needed agency workers to cover staff absences. They believed the service was far sharper and more outcomes focussed. There was evidently a high level of knowledge and expertise in the team which was shared well to develop and improve practice. Workers were being creative with carrying direct work and were optimistic they would have more capacity with the more proactive approach to managing casework. Transition arrangements with adult services had improved but were still not starting early enough to give time for consistently good planning. Workers welcomed arrangements for joint working with staff from the children's community teams on child protection and court cases.

4.8 Care planning was timely and showed some improvement in the quality of work but this was not consistent. The recording of plans was better and templates had been revised but further work was needed. Both 'child in need' and care plans were not routinely outcome focussed; priorities were not clearly identified and it was often unclear what had been achieved and which actions were outstanding. It was not evident how children, young people and carers had been engaged in the planning process nor were their views well captured. The timeliness and recording of statutory visits had improved. It was clear that social workers had a better understanding of the purpose of this work and the importance of working with children and young people to achieve their potential.

Service users spoken to by inspectors were very positive about the impact that social workers had on their lives.

Practice example:

A social worker from the children with disabilities team had produced a pictorial letter to help two parents with learning difficulties understand the PLO process.

4.9 The looked after population had reduced from 457 to 429 since the last inspection and had stabilised. The looked after children's team held 193 LAC cases and were fully staffed but additional posts had been agreed so that long term cases could transfer from the community children's teams. Additional capacity was also needed to carry out work identified in the LAC reduction strategy to discharge care orders where appropriate and support applications for Special Guardianship Orders. The team was working to achieve better placement stability and provide more targeted support for children and young people. Inspectors saw some examples of excellent life story work and also creative ways of communicating with parents with learning difficulties. Both foster carers and social workers had identified there was a gap in services available to support looked after children with emotional or mental health needs. Senior managers had committed to spot purchase services if needs were identified; however this did not appear to have been communicated to all members of staff. Inspectors had some concerns that this approach could result in an inconsistent response to meeting needs.

4.10 The arrangements for providing 'leaving care' support had changed a short time before the inspection took place. The team were divided in their opinion about the changes which meant that all those former relevant young people (aged 18+) would be allocated just to personal advisors and the relevant young people (aged 16 and 17) would be allocated to social workers. The team caseload was high at 286, 109 of whom were still looked after. Workers were very committed to providing relevant support for care leavers and were keen to develop a drop-in resource to provide easier access to support and services. The timeliness of pathway plans had improved but the quality of planning is an area for development. The projected increase in workload for the next two years has been referenced earlier in the report.

4.11 The timeliness of looked after children's reviews had further improved to 96% in quarter 3 of 2014/15. There was evidence that the child's needs were effectively considered but plans were not consistently updated, and progress was not easily tracked. Reviews were not well attended by children and young people and independent reviewing officers reported they did not have the capacity to routinely meet with them before reviews. There were three vacancies in the team and due to difficulty recruiting into these particular posts the work was being covered by sessional workers. The roles and responsibilities within the IRO team had been revised so that all workers chaired both looked after children's reviews and case conferences. There has been recognition that the team of IROs had not got the skills and experience to deliver on the expectations of the service, and some social workers expressed dissatisfaction with the quality

of the work of the IROs. An improvement plan for IROs had been introduced which included shadowing social workers, opportunities to observe others chairing reviews and conferences and training.

4.12 Child protection was identified as one of the priority areas in need of improvement at the time of the last inspection. The improved timeliness for child protection processes had been sustained. Overall inspectors found that the quality of the work had improved, and workers showed a high level of confidence in their ability to make effective use of child protection processes. Child protection planning was found to be more outcomes-focussed but overall remained an area for development. Some social workers believed they were unable to amend the child protection plan which is initially drawn up at the child protection conference. This resulted in some plans not reflecting changes in circumstances or effectively prioritising actions and capturing progress. The quality of child protection case conference minutes remained variable, and improvement work was in hand. Core group working had improved in quality and evidenced better multi agency engagement but recording of the activity and progress did not always align with the child protection plan. There was little evidence of how parents, carers and young people were engaged in the process and their views were not routinely captured.

Parents' view:

'No-one explained what a child protection conference was for, it came as a shock, the police were there, I felt I was ambushed sitting there listening to hear that (previous convictions of family) and then to be asked to leave the room for 10 minutes, it was awful.'

4.13 Social workers and managers were being well supported by legal services. Decision making around the thresholds for instigating the Public Law Outline (PLO) was appropriate in the cases reviewed by inspectors. At the time of the inspection there were 46 cases in pre-proceedings and 23 cases in care proceedings, a reduction from the previous year. Some cases spent an extended period of time in the pre-proceedings stage. There appeared to be a lack of routine review of progress against agreed criteria, and a number of cases had drifted. Once the decision was made to instigate court proceedings cases were well monitored. Social workers appeared to be using the PLO notification as a tool to alert parents to an escalation of concern. It was evident that some families made more progress after receiving the formal notification as it gave them a clear understanding of the authority's intent. However clear timescales and timely reviews should be agreed at the outset to better identify and track whether the necessary changes were being made in the medium and longer term. Additional capacity had been provided to support one team where there was a high number of PLOs in place. Principal officers were planning to strengthen oversight of the decision making around the process which should include reviewing timescales for the period a case should remain in the pre-proceedings stage.

4.14 Partner agencies reported that contacting the 'out of hours' service still proved problematic at certain times. The arrangements for the service had been reviewed by the authority and plans were in place to increase capacity to ensure a more consistent and timely response.

Quote from a young person:

'Route 16 are brilliant. There is nothing I can think of that they could do better. If I had money I would donate some to R16 so they could help more kids like me.'

Appendix 1

Recommendations from the inspection completed in November 2013.

Providing direction

1. Strong political and corporate support will need to be maintained to ensure that the continued improvement of children's social services remains a priority.
2. The Strategic Improvement plan should be amended to become more outcome-focussed so that progress can be assessed effectively and areas for further development can be more easily identified.

Delivering social services

Workforce

3. There should be a continuing focus on the delivery of the workforce strategy including:
 - a. Retention of staff and increased stability in the arrangements for agency workers.
 - b. Developing an induction pack which is also available to agency workers and includes management's expectations of competence for staff at the end of the probationary period.
 - c. The development of on-line policies and procedures.
 - d. Consideration of the impact that any reduction in HR support would have on the improvement agenda.
 - e. Workforce profiles of staff turnover and experience should be consistent in whether agency workers are included.
 - f (i). The roles and responsibilities of deputy team managers in relation to supervision of staff should be clarified with consultation and communication with all staff.
 - f (ii). The roles and responsibilities of consultant social workers in relation to supervision of staff should be clarified with consultation and communication with all staff.
 - g. Partner agencies need to be engaged more effectively in promoting multi-agency training.

- h. Learning and development opportunities especially in relation to child protection and care planning should be maximised and integrated into supervision and team meetings.
- i. A continued focus on building staff's confidence in the management of bullying and oppressive practice.
- j. A consistent approach should be developed in arrangements to covering staff absence especially for covering statutory visits.

Performance Management/Quality Assurance

- 4. The collection of data relating to the access to children's services should be consistently reported.
- 5. The analysis of performance data should be improved so that the implications of changes are evident. Areas for development should be highlighted in addition to improvements.
- 6. Plans to implement the quality assurance framework should be prioritised and include using the outcome of complaints to inform practice.
- 7. Further work is needed to consolidate the progress made in improving the recording of information and decision making on plans, case conference minutes and core group working.

Shaping services

- 8. The Participation, Engagement and Advocacy protocol should be reviewed to ensure that the proposals are feasible.
- 9. All social workers and managers should be kept informed of the development of the Think Family development of preventative services.
- 10. The harmonisation of thresholds work being completed by the Think Family Partnership should be defined and clearly communicated.
- 11. The profile of the looked after population should include the length of time a child has been looked after and whether they are placed out of county.

Getting help

- 12. Social workers need further guidance in the consideration of risk and how information collected is validated and recorded.
- 13. The practice of carrying out desktop initial assessments should be discontinued.

14. Arrangements to audit contacts which do not proceed to referrals and referrals which result in no further action following initial assessment should be established without delay.
15. Arrangements for the transfer of cases between teams especially in relation to those out of the intake team should be agreed, communicated to all staff and implemented as soon as possible.
16. Work to promote the consistency in the quality of assessments should retain a strong focus.
17. Improvement is required in the quality of care planning for children and young people.
18. Further review of 'children in need' cases is required to rationalise demand and ensure social work support is at an appropriate level.
19. Social workers need more guidance about the purpose of statutory visits for both child protection and looked after children and how to record them.
20. Arrangements to review permanency plans for looked after children especially those held in the community children's teams should remain a priority.

Arrangements to protect vulnerable children

21. Social workers need further support to develop better skills in carrying out.
 - i) Section 47 investigations;
 - ii) Developing and reviewing child protection plans;
 - iii) Core group working.
22. The local authority should review the 'out of hours' service to ensure there are arrangements in place to provide a consistent timely response.

Appendix 2

Information about the inspection.

Methodology

Fieldwork for this inspection was undertaken during the weeks commencing February 9th 2015 and February 23rd 2015.

Inspection evidence was gathered from:

Strategic and policy documents; performance indicators for 2014/15; workforce and workload data; and case file audits.

64 case files.

12 interviews with parents, carers and young people.

Five observations of practice.

21 individual interviews with case workers, 8 team managers and 2 IROs.

A sample of complaints and representations and staff supervision notes.

A range of interviews with elected members, senior and operational managers, legal services, partner agencies, 9 operational teams.

A staff survey – we received 51 responses.

The Inspection Team

The inspection team consisted of 3 inspectors employed by CSSIW, 2 fee-paid inspectors and the area manager for NPT.

Lead inspector: Pam Clutton;

Area Manager: Ann Rowling;

Team inspectors: Bobbie Jones, Katy Young;

Fee Paid Inspectors: Bryan Isaac and Karen Tudor.